

Medical Assistance Provider Bulletin

Attention: All Title XIX Certified Audiologists and
Hearing Aid Dealers

Subject: New HCFA 1500 Claim Form, Revised Prior
Authorization and Billing Instructions

Date: March 27, 1992

Code: MAPB-092-025-D, MAPB-092-006-HA

Department of Health and Social Services, Division of Health,
Bureau of Health Care Financing, P.O. Box 309, Madison, Wisconsin 53701

TABLE OF CONTENTS

- I. INTRODUCTION
- II. NEW NATIONAL HCFA 1500 CLAIM FORM (12/90)
- III. PLACE OF SERVICE CODES
- IV. PRIOR AUTHORIZATION AND BILLING FOR SERVICES USING A NON-SPECIFIC PROCEDURE CODE
- V. BILLING FOR UNLISTED AUDIOLOGIST PROCEDURE CODE 92599
- VI. 1992 CURRENT PROCEDURAL TERMINOLOGY (CPT)
- VII. ATTACHMENTS

I. INTRODUCTION

This Medical Assistance Provider Bulletin (MAPB) provides important information on the Wisconsin Medical Assistance Program's (WMAF) implementation of a new HCFA 1500 claim form and revised prior authorization and billing instructions for durable medical equipment. **It is important that providers review this information carefully and share it with billing staff.**

II. NEW NATIONAL HCFA 1500 CLAIM FORM (12/90)

The Health Care Financing Administration (HCFA) has mandated that all state Medicaid programs use the revised National HCFA 1500 claim form (dated 12/90). All paper claims received by EDS from March 15, 1992, through May 1, 1992, may be submitted on either the current HCFA 1500 claim form (dated 1/84) or the new claim form.

All claims, including the resubmission of any previously denied claims, received by EDS after May 1, 1992, must be submitted on the HCFA 1500 claim form dated 12/90. Claims received by EDS after May 1, 1992, on claim forms other than the HCFA 1500 (12/90) claim form, will be denied. Modified versions of the National HCFA 1500 claim form may also be denied.

Please allow ample mailing time to ensure that claims submitted on the current HCFA 1500 claim form are received at EDS by May 1, 1992.

Crossover claims for Medicare Part B coinsurance and deductible allowed charges may be submitted on either the new or old HCFA 1500 claim form.

There are no changes to the submission of electronic claims.

A sample claim form and detailed claim form completion instructions are included in Attachments 1 and 2 of this MAPB. All claims received by EDS on the new HCFA 1500 claim form must be completed according to these instructions. The instructions in this MAPB completely replace the instructions that you received in MAPB-087-015-D/002-HA dated September 1, 1987.

As you read the completion instructions in Attachment 2, please watch for the following changes:

- The procedure code is now indicated in Element 24D of the claim form, but the procedure code description is no longer required.
- The performing provider number is now required in Element 24K for each line item of the claim form, but the performing provider name is no longer required.
- An emergency condition must be indicated for each applicable line item on the claim form by entering an "E" in Element 24I.
- Services resulting from HealthCheck (EPSDT) referrals must be indicated for each applicable line item on the claim form by entering "H" for HealthCheck services in Element 24H.

The National HCFA 1500 claim form is not provided by either the WMAP or EDS, but may be obtained from a number of forms suppliers. One such source is:

State Medical Society Services, Inc.
P.O. Box 1109
Madison, WI 53701
(608) 257-6781
1-800-362-9080

III. PLACE OF SERVICE CODES

Until further notice, the WMAP will continue to require the single-digit place of service codes on the HCFA 1500 claim, not the two-digit place of service codes required by Medicare. Claims with Medicare Part B allowed charges that cross over to the WMAP from WPS will have the place of service codes automatically converted to single-digit codes for claims processing. However, paper crossover claims, as well as all paper and electronic claims submitted directly to the WMAP, must indicate the appropriate single-digit place of service code.

IV. PRIOR AUTHORIZATION AND BILLING FOR SERVICES USING A NON-SPECIFIC PROCEDURE CODE

This section replaces some of the information contained in MAPB-091-020-D and MAPB-090-005-HA dated June 10, 1991.

Nonspecific procedure codes are to be used only when there is not a distinct procedure code for the service being provided. Whenever possible, use the most specific codes available, rather than the general code W6999.

The WMAP is implementing a new way to process nonspecific procedure codes. Effective with prior authorization requests received by EDS on and after April 1, 1992, the maximum allowable reimbursement for these codes will be determined when the prior authorization is approved. Reimbursement is then the billed amount or the amount on the Prior Authorization Request Form (PA/RF), whichever is less.

This means that nonspecific codes can be billed electronically or billed by using the revised HCFA 1500 for dates of service on or after April 1, 1992. Refer to Attachment 3 of this MAPB for the list of nonspecific codes priced under this new process.

Process for Requesting Prior Authorization and Submitting Claims for Nonspecific Codes and Repair Codes

A. Submitting a Prior Authorization Request Form (PA/RF)

1. Include a description of each item with a nonspecific procedure code in sufficient detail to enable the WMAP to set the maximum allowable reimbursement. This must include the manufacturer's item description (e.g., name and model number).

2. Do not include a modifier in element 15 unless modifier "01" is necessary to indicate a bilateral procedure. (Refer to "Receiving an Approved PA/RF" and "Billing for Nonspecific Codes" for further information on modifiers.)
3. Always indicate a quantity of one in element 19 for nonspecific codes. If requesting two identical items within a nonspecific code, identify this as a "pair" in the description or by using a bilateral modifier when allowed.

B. Receiving an Approved PA/RF

1. The maximum allowable reimbursement is indicated for repair and nonspecific procedure codes in element 20. This is initialed and initiated by the state consultant.
2. If several items are approved under one nonspecific code, procedure code modifiers (numbers 11-22) are assigned in element 15 to each approved item by the consultant.

C. Submitting Amendments to An Approved PA/RF

1. The only way to obtain a higher level of reimbursement than is identified on the PA/RF for nonspecific codes is by submitting a PA amendment request. An amendment may be submitted if the provider can document that the approved maximum allowable reimbursement does not cover the cost of parts or repairs.
2. If an amended PA/RF is approved after you have received reimbursement, submit an adjustment request for additional reimbursement which indicates that the PA maximum has been changed. Refer to Part A Section IX of the WMAP Provider Handbook for information about adjustment requests.

D. Billing for Nonspecific Codes

1. Use a quantity of "1" to bill for each detail of a nonspecific code.
2. When a modifier is assigned to a nonspecific procedure code on the approved PA/RF, the modifier must be used when billing for the specific authorized items.
3. Reimbursement is the billed amount or the amount approved on the PA/RF, whichever is less.

Refer to Attachments 4, 4a and 1 for a sample PA/RF, PA/RF approval, and claim form.

V. BILLING FOR UNLISTED AUDIOLOGIST PROCEDURE CODE 92599

Claims for 92599 (unlisted otorhinolaryngological service or procedure) require documentation describing the procedure performed. The provider may use element 19 on the HCFA 1500 claim form (Reserved for Local Use) if the procedure can be clearly described in a few words. If this space is not sufficient, providers should write "see attached" in element 19 and attach additional documentation. This documentation may be in the form of a physician's prescription, history and physical exam report, or a medical progress note. The documentation must be sufficient to allow the medical consultant to determine the procedure performed as well as the medical necessity of the procedure. Claims for procedure code 92599 which do not have documentation either on the claim or attached to the claim are denied.

VI. 1992 CURRENT PROCEDURAL TERMINOLOGY (CPT)

The Department of Health and Social Services is currently in the process of identifying appropriate coverage and pricing policies for the new durable medical equipment (DME) procedures identified in the 1992 Current Procedural Terminology published by the American Medical Association. Providers should continue to use the allowable procedures identified in the Durable Medical Index issued December 15, 1991, as modified by this MAPB until further notice. Claims for DME procedures which were newly added to the CPT in 1992 will be denied. We anticipate that appropriate new codes will be added, effective for dates of service on or after July 1, 1992.

ATTACHMENTS

1. National HCFA 1500 Claim Form Sample
2. National HCFA 1500 Claim Form Completion Instructions
3. List of Procedures In Which Reimbursement Is Determined At Time of Prior Authorization
4. Prior Authorization Request Form (PA/RF) Sample
- 4a. Prior Authorization Request Form (PA/RF) Approval Sample

ATTACHMENT 1

NATIONAL HCFA 1500 CLAIM FORM SAMPLE

PICA HEALTH INSURANCE CLAIM FORM PICA																																																																																													
<div style="display: flex; justify-content: space-between;"> <div> 1 MEDICARE <input type="checkbox"/> (Medicare #) <input type="checkbox"/> 2 PATIENT'S NAME (Last Name, First Name, Middle Initial) Recipient, Im A 5 PATIENT'S ADDRESS (No. Street) 609 Willow St CITY Anytown STATE WI ZIP CODE 55555 TELEPHONE (Include Area Code) (XXX) XXX-XXXX </div> <div> 3 PATIENT'S BIRTH DATE MM DD YY MM DD YY M <input checked="" type="checkbox"/> F <input type="checkbox"/> 6 PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> 8 PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/> 10. IS PATIENT'S CONDITION RELATED TO a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO 10d. RESERVED FOR LOCAL USE </div> <div> 1a INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 1234567890 4 INSURED'S NAME (Last Name, First Name, Middle Initial) 7 INSURED'S ADDRESS (No. Street) CITY STATE ZIP CODE TELEPHONE (INCLUDE AREA CODE) 11 INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> b. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d</i> </div> </div>																																																																																													
<div style="display: flex; justify-content: space-between;"> <div> 9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) OI-P a. OTHER INSURED'S POLICY OR GROUP NUMBER b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> c. EMPLOYER'S NAME OR SCHOOL NAME d. INSURANCE PLAN NAME OR PROGRAM NAME </div> <div> 12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____ </div> <div> 13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____ </div> </div>																																																																																													
<div style="display: flex; justify-content: space-between;"> <div> 14 DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY 17 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE I.M. Prescribing </div> <div> 15 IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY 17a. I.D. NUMBER OF REFERRING PHYSICIAN 12345678 </div> <div> 16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY 18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY </div> </div>																																																																																													
<div style="display: flex; justify-content: space-between;"> <div> 19 RESERVED FOR LOCAL USE 21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) 1 V539 3 _____ 2 _____ 4 _____ </div> <div> 20 OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES 22 MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23 PRIOR AUTHORIZATION NUMBER 1234567 </div> </div>																																																																																													
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<div style="display: flex; justify-content: space-between;"> <div> 25 FEDERAL TAX I.D. NUMBER SSN EIN 26 PATIENT'S ACCOUNT NO. 1234JED </div> <div> 27 ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO </div> <div> 28 TOTAL CHARGE \$ XXXX XX </div> <div> 29 AMOUNT PAID \$ XXX XX </div> <div> 30 BALANCE DUE \$ XXXX XX </div> </div>																																																																																													
<div style="display: flex; justify-content: space-between;"> <div> 31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) I.M. Authorized MM/DD/YY SIGNED _____ DATE _____ </div> <div> 32 NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) 33 PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # I.M. Billing 1 W. Williams Anytown, WI 55555 PIN# _____ GRP# 87654321 </div> </div>																																																																																													

ATTACHMENT 2

**NATIONAL HCFA 1500 CLAIM FORM COMPLETION INSTRUCTIONS
FOR AUDIOLOGY AND HEARING AID SERVICES**

To avoid denial or inaccurate claim payment, providers must use the following claim form completion instructions. Enter all required data on the claim form in the appropriate element. Do not include attachments unless instructed to do so. All elements are required unless "not required" is specified.

Wisconsin Medical Assistance recipients receive a Medical Assistance identification card upon initial enrollment into the Wisconsin Medical Assistance Program (WMAF) and at the beginning of each month thereafter. Providers should always see this card before rendering services. Please use the information exactly as it appears on the Medical Assistance identification card to complete the patient and insured information.

ELEMENT 1 - Program Block/Claim Sort Indicator

Enter claim sort indicator "D" or "T" for the service billed in the Medicaid check box. Claims submitted without this indicator are denied.

<u>Provider Type</u>	<u>Type of Service</u>	<u>Claim Sort Indicator</u>
Audiologist	Audiological Services (i.e., therapies)	T
Audiologist	Servicing and supplying of hearing aids	D
Hearing Aid Dealer	Servicing and supplying of hearing aids	D

ELEMENT 1a - INSURED'S LD. NUMBER

Enter the recipient's ten-digit Medical Assistance identification number as found on the current Medical Assistance identification card. This element must contain no other numbers, unless the claim is a Medicare crossover claim, in which case the recipient's Medicare number may also be indicated.

ELEMENT 2 - PATIENT'S NAME

Enter the recipient's last name, first name, and middle initial as it appears on the current Medical Assistance identification card.

NOTE: A provider may submit claims for an infant if the infant is ten days old or less on the date of service and the mother of the infant is a Medical Assistance recipient. To bill for an infant using the mother's Medical Assistance identification number, enter the mother's last name followed by "Newborn" in element 2. Enter the infant's date of birth in element 3. In element 4 enter the mother's name followed by "Mom" in parentheses. Finally, in element 1A enter the mother's ten-digit Medical Assistance identification number.

ELEMENT 3 - PATIENT'S BIRTH DATE, PATIENT'S SEX

Enter the recipient's birth date in MM/DD/YY format (e.g., February 3, 1955, would be 02/03/55) as it appears on the Medical Assistance identification card. Specify if male or female with an "X."

ELEMENT 4 - INSURED'S NAME (not required)

ELEMENT 5 - PATIENT'S ADDRESS

Enter the complete address of the recipient's place of residence.

ELEMENT 6 - PATIENT RELATIONSHIP TO INSURED (not required)

ELEMENT 7 - INSURED'S ADDRESS (not required)

ELEMENT 8 - PATIENT STATUS (not required)

ELEMENT 9 - OTHER INSURED'S NAME

Third party insurance (commercial insurance coverage) must be billed prior to billing the WMAP, unless the service does not require third party billing according to Section IX of Part A of the WMAP Provider Handbook.

When "Other Coverage" of the recipient's Medical Assistance identification card indicates HPP, BLU, WPS, CHA, or OTH, one of the following codes **MUST** be indicated in the first box of element 9. The description is not required, nor is the policyholder, plan name, group number, etc. (Elements 9a, 9b, 9c, and 9d are not required.)

Code	Description
OI-P	PAID by other insurance, in whole or in part
OI-D	DENIED by other insurance, benefits exhausted, deductible not reached, non-covered service, etc.
OI-C	Recipient or other party will NOT COOPERATE
OI-S	SENT claim, but insurance company did not respond
OI-R	RECIPIENT denies coverage
OI-E	ERISA plan denies being prime
OI-A	Benefits NOT ASSIGNABLE

When "Other Coverage" of the recipient's Medical Assistance identification card indicates "HMO" or "HMP", one of the following disclaimer codes must be indicated, if applicable:

Code	Description
OI-P	PAID by other insurance, in whole or in part
OI-H	DENIED by the HMO or HMP for one of the following reasons: <ul style="list-style-type: none">- noncovered service- applied to deductible or copayment- family planning services (if WPS-HMP only)

Important Note: The provider may not use OI-H if the HMO or HMP denied payment because an otherwise covered service was not rendered by a designated provider.

When the provider has not billed other insurance because the "Other Coverage" of the recipient's Medical Assistance identification card is blank, or the service does not require third party billing according to Section IX of Part A of the WMAP Provider Handbook, this element may be left blank.

ELEMENT 10 - IS PATIENT'S CONDITION RELATED TO (not required)

ELEMENT 11 - INSURED'S POLICY, GROUP OR FECA NUMBER

The first box of this element is used by the WMAP for Medicare information. (Elements 11a, 11b, 11c, and 11d are not required.) Medicare must be billed prior to billing the WMAP. When the recipient's Medical Assistance identification card indicates Medicare coverage, but Medicare does not allow any charges, one of the following Medicare disclaimer codes **MUST** be indicated. The description is not required.

<u>Code</u>	<u>Description</u>
M-1	Medicare benefits exhausted
M-5	Provider not Medicare certified
M-6	Recipient not Medicare eligible
M-7	Medicare disallowed (denied) service
M-8	Not a Medicare benefit

If a recipient's Medical Assistance identification card indicates no Medicare coverage, this element may be left blank. If Medicare allows an amount on the recipient's claim, the Explanation of Medicare Benefit (EOMB) must be attached to the claim and this element must be left blank. Refer to Appendix 17 of Part A of the WMAP Provider Handbook for further information regarding the submission of this type of claim.

ELEMENTS 12 AND 13 - AUTHORIZED PERSON'S SIGNATURE

(Not required since the provider automatically accepts assignment through Medical Assistance certification.)

ELEMENT 14 - DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (not required)

ELEMENT 15 - IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS (not required)

ELEMENT 16 - DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (not required)

ELEMENT 17 - NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

When required, enter the referring or prescribing physician's name.

ELEMENT 17a - ID. NUMBER OF REFERRING PHYSICIAN

Enter the referring provider's eight-digit Medical Assistance provider number if certified by the WMAP. If the referring provider is not WMAP-certified, enter the provider's license number.

ELEMENT 18 - HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (not required)

ELEMENT 19 - RESERVED FOR LOCAL USE

If an unlisted procedure code is billed, providers may describe the procedure in this element. If there is not enough space for the description, or if multiple unlisted procedure codes are being billed, providers must attach documentation to the claim describing the procedure(s). In this instance, providers must indicate "See Attachment" in element 19.

ELEMENT 20 - OUTSIDE LAB

If laboratory services are billed, check either "yes" or "no" to indicate whether an outside lab was used.

ELEMENT 21 - DIAGNOSIS OR NATURE OF ILLNESS OR INJURY

The International Classification of Disease (ICD) diagnosis code must be entered for each symptom or condition related to the services provided. Manifestation ("M") codes are not acceptable. List the primary diagnosis first. Etiology ("E") codes may not be used as a primary diagnosis. The diagnosis description is not required.

ELEMENT 22 - MEDICAID RESUBMISSION (not required)**ELEMENT 23 - PRIOR AUTHORIZATION**

Enter the seven-digit prior authorization number from the approved prior authorization request form. Services authorized under multiple prior authorizations must be billed on separate claim forms with their respective prior authorization numbers.

ELEMENT 24A - DATE(S) OF SERVICE

Enter the month, day, and year for each procedure using the following guidelines:

- When billing for one date of service, enter the date in MM/DD/YY format in the "From" field.
- When billing for two, three, or four dates of service on the same line, enter the first date of service in MM/DD/YY format in the "From" field, and subsequent dates of service in the "To" field by listing only the date(s) of the month (i.e., DD, DD/DD, or DD/DD/DD).

It is allowable to enter up to four dates of service per line if:

- All dates of service are in the same calendar month.
- All services performed are identical.
- All procedures have the same type of service code.
- All procedures have the same place of service code.
- All procedures were performed by the same provider.
- The same diagnosis is applicable for each procedure.
- The charge for all procedures is identical. (Enter the total charge per detail line in element 24F.)

- The number of services performed on each date of service is identical.
- All procedures have the same HealthCheck or family planning indicator.
- All procedures have the same emergency indicator.

ELEMENT 24B - PLACE OF SERVICE

Enter the appropriate WMAP single-digit place of service code for each service.

Numeric	Description
1	Inpatient
3	Office
4	Home
7	Nursing Home
8	Skilled Nursing Facility

ELEMENT 24C - TYPE OF SERVICE CODE

Enter the appropriate single-digit type of service code.

Alpha	Description (Audiology Services)
B	Diagnostic Medical (Total)
P	Purchase
R	Rental
Alpha	Description (Hearing Aid Dealer Services)
P	Purchase
R	Rental

ELEMENT 24D - PROCEDURES, SERVICES, OR SUPPLIES

Enter the appropriate five-character procedure code and, if applicable, a two-character modifier.

ELEMENT 24E - DIAGNOSIS CODE

When multiple procedures related to different diagnoses are submitted, column E must be used to relate the procedure performed (element 24D) to a specific diagnosis in element 21. Enter the number (1, 2, 3, or 4) which corresponds to the appropriate diagnosis in element 21.

ELEMENT 24F - CHARGES

Enter the total charge for each line.

ELEMENT 24G - DAYS OR UNITS

Enter the total number of services billed for each line. A decimal must be indicated when a fraction of a whole unit is billed. For a hearing aid rental service, the total number of days the item was rented should be entered as the quantity. This must coincide with the date range indicated. For hearing aid batteries, enter the number of batteries.

ELEMENT 24H - EPSDT/FAMILY PLANNING

Enter an "H" for each procedure that was performed as a result of a HealthCheck (EPSDT) referral. Enter an "F" for each family planning procedure. Enter a "B" if BOTH HealthCheck and family planning services were provided. If HealthCheck/family planning do not apply, leave this element blank.

ELEMENT 24I - EMG

Enter an "E" for each procedure performed as an emergency, regardless of the place of service.

ELEMENT 24J - COB (not required)**ELEMENT 24K - RESERVED FOR LOCAL USE**

Enter the eight-digit, Medical Assistance provider number of the performing provider for each procedure, if it is different than the billing provider number indicated in element 33.

When applicable, enter the word "spenddown" and under it, the spenddown amount on the last detail line of element 24K directly above element 30. Refer to Section IX of Part A of the WMAP Provider Handbook for information on recipient spenddown.

ELEMENT 25 - FEDERAL TAX ID NUMBER (not required)**ELEMENT 26 - PATIENT'S ACCOUNT NO.**

Optional - provider may enter up to 12 characters of the patient's internal office account number. This number will appear on the EDS Remittance and Status Report.

ELEMENT 27 - ACCEPT ASSIGNMENT

(Not required, provider automatically accepts assignment through Medical Assistance certification.)

ELEMENT 28 - TOTAL CHARGE

Enter the total charges for this claim.

ELEMENT 29 - AMOUNT PAID

Enter the amount paid by other insurance. If the other insurance denied the claim, enter \$0.00. (If a dollar amount is indicated in element 29, "OI-P" must be indicated in element 9.)

ELEMENT 30 - BALANCE DUE

Enter the balance due as determined by subtracting the recipient spenddown amount in element 24K and the amount paid in element 29 from the amount in element 28.

ELEMENT 31 - SIGNATURE OF PHYSICIAN OR SUPPLIER

The provider or the authorized representative must sign in element 31. The month, day, and year the form is signed must also be entered in MM/DD/YY format.

NOTE: This may be a computer-printed or typed name and date, or a signature stamp with the date.

ELEMENT 32 - NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED

If the services were provided to a recipient in a nursing home (place of service 7 or 8), indicate the nursing home's eight-digit Medical Assistance provider number.

ELEMENT 33 - PHYSICIAN'S, SUPPLIERS BILLING NAME, ADDRESS, ZIP CODE AND PHONE #

Enter the provider's name (exactly as indicated on the provider's notification of certification letter) and address of the billing provider. At the bottom of element 33, enter the billing provider's eight-digit Medical Assistance provider number.

ATTACHMENT 3

**PROCEDURE CODES IN WHICH REIMBURSEMENT
IS DETERMINED AT TIME OF PRIOR AUTHORIZATION**

AUDIOLOGY

W6808	Communicator (Including Accessories)
W6999	Unlisted Hearing Aid Services

HEARING AID DEALERS

W6999	Unlisted Hearing Aid Services
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ATTACHMENT 4

PRIOR AUTHORIZATION REQUEST FORM (PA/RF) SAMPLE

MAIL TO: E.D.S. FEDERAL CORPORATION PRIOR AUTHORIZATION UNIT 6406 BRIDGE ROAD SUITE 88 MADISON, WI 53784-0088				PRIOR AUTHORIZATION REQUEST FORM <div style="border: 1px solid black; padding: 2px; display: inline-block;">PA/RF</div> (DO NOT WRITE IN THIS SPACE) ICN # A.T. # P.A. # 1234567				1 PROCESSING TYPE <div style="border: 1px solid black; padding: 10px; width: 80px; margin: 0 auto;">130</div>	
2 RECIPIENT'S MEDICAL ASSISTANCE ID NUMBER 1234567890				4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE) 609 Willow St. Anytown, WI 55555					
3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL) Recipient, Im A									
5 DATE OF BIRTH MM/DD/YY			6 SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>		8 BILLING PROVIDER TELEPHONE NUMBER (XXX) XXX-XXXX				
7 BILLING PROVIDER NAME, ADDRESS, ZIP CODE: I.M. Provider 1 W. Williams Anytown, WI 55555					9 BILLING PROVIDER NO. 87654321				
					10 DX: PRIMARY V539				
					11 DX: SECONDARY				
					12 START DATE OF SOI:		13 FIRST DATE RX:		
14	15	16	17	18	19	20			
PROCEDURE CODE	MOD	POS	TOS	DESCRIPTION OF SERVICE	QR	CHARGES			
W6808		4	P	Touch talker communication device	1	XXXX.XX			
W6808		4	P	Individualized vocabulary package	1	XXX.XX			
W6808		4	P	Memory transfer interface	1	XXX.XX			
W6808		4	P	Protective carrying case	1	XX.XX			
W6808		4	P	Adapter for Imagewriter II	1	XX.XX			
					TOTAL CHARGE	21 XXXX.XX			

22 An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

23 MM/DD/YY 24 I. M. Provider
 DATE REQUESTING PROVIDER SIGNATURE

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION: <input type="checkbox"/> APPROVED <input type="checkbox"/> MODIFIED — REASON: <input type="checkbox"/> DENIED — REASON: <input type="checkbox"/> RETURN — REASON:	<div style="border: 1px solid black; width: 100px; height: 20px; margin: 0 auto;"></div> GRANT DATE	<div style="border: 1px solid black; width: 100px; height: 20px; margin: 0 auto;"></div> EXPIRATION DATE	PROCEDURE(S) AUTHORIZED QUANTITY AUTHORIZED
---	---	--	---

DATE

CONSULTANT/ANALYST SIGNATURE

ATTACHMENT 4a

PRIOR AUTHORIZATION REQUEST FORM (PA/RF)
APPROVAL SAMPLE

MAIL TO:

E.D.S. FEDERAL CORPORATION
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PRIOR AUTHORIZATION REQUEST FORM

PA/RF (DO NOT WRITE IN THIS SPACE)

ICN #
A.T. #
P.A. # 1234567

1 PROCESSING TYPE

130

2 RECIPIENT'S MEDICAL ASSISTANCE ID NUMBER 1234567890		4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE) 609 Willow St. Anytown, WI 55555	
3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL) Recipient, Im A			
5 DATE OF BIRTH MM/DD/YY	6 SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>	8 BILLING PROVIDER TELEPHONE NUMBER (XXX) XXX-XXXX	
7 BILLING PROVIDER NAME, ADDRESS, ZIP CODE I.M. Provider 1 W. Williams Anytown, WI 55555		9 BILLING PROVIDER NO. 87654321	
		10 DX: PRIMARY V539	
		11 DX: SECONDARY	
		12 START DATE OF SOI:	13 FIRST DATE RX.

4 PROCEDURE CODE	15 MOD	16 POS	17 TOS	18 DESCRIPTION OF SERVICE	19 QR	20 CHARGES
W6808	11	4	P	Touch talker communication device	1 med. com. device	price XXX.XX
W6808	12	4	P	Individualized vocabulary package	1 initials	price XXX.XX
W6808	13	4	P	Memory transfer interface	1 initials	price XXX.XX
W6808	14	4	P	Protective carrying case	1 initials	price XX.XX
W6808	15	4	P	Adapter for Imagewriter II	1 initials	price XX.XX

22 An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

23 MM/DD/YY
DATE

24 *J. M. Provider*
REQUESTING PROVIDER SIGNATURE

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:

☒
APPROVED

☐
MODIFIED — REASON:

☐
DENIED — REASON:

☐
RETURN — REASON:

MM/DD/YY
GRANT DATE

MM/DD/YY
EXPIRATION DATE

PROCEDURE(S) AUTHORIZED QUANTITY AUTHORIZED
as above

MM/DD/YY

J. M. Consultant